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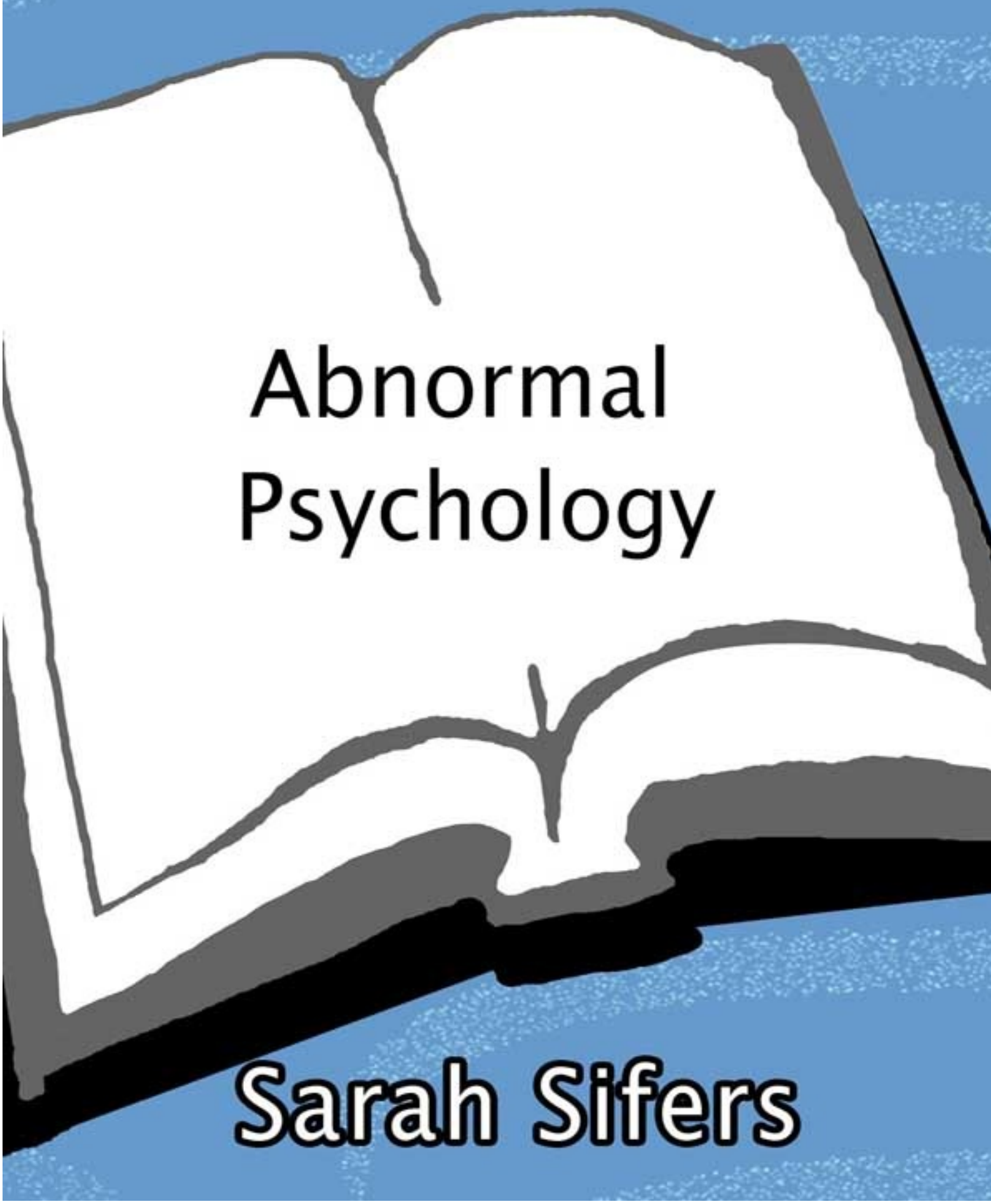

Abnormal Psychology

Sarah Sifers

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3rd Edition

Sarah K. Sifers Ph.D.
Minnesota State University Mankato
Mankato, MN

Timothy W. Costello, Ph.D.
Joseph T. Costello, Ph.D.

Contributing Editor
Brad Mossbarger, Ph.D.
Austin Peay State University
Clarksville, TN

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Preface

The goal of this outline is to provide you with information about abnormal psychology. Specifically, you will find the symptoms, onset, causes, course, and common treatment methods of th most frequently noted disorders contained in the *Diagnostic and Statistical Manual,* 4th Edition, Tex Revision. The outline provides information about and examples of research in abnormal psychology. Furthermore, it aims to educate you about historical and modern issues in abnormal psychology, including legal and social concerns. The comprehensive and yet concise nature of this outline make i an ideal resource not only for students of abnormal psychology but also for professionals and educators in psychology and related fields.

This outline's format provides an easy reference and helps you organize the material, thus facilitating learning. This concise, easy-to-access layout makes it ideal for a quick review or for gaining a basic understanding. The information provided includes a balance of historical context and modern research from multiple perspectives within the field. Each chapter contains review questions to assess for comprehension of the material and suggested readings if you would like a more in-depth or first-hand account of the topics covered. The outline also includes a glossary and index to facilitat rapid reference to key terms.

The outline begins with an overview of the field of abnormal psychology followed by the history of the discipline. Next is an outline of basic research strategies and issues within abnormal psychology, plus a description of the common theoretical orientations and their strengths and weaknesses. Following this introduction is a chapter on the assessment and classification of psychological disorders, and then a discussion of common approaches to the treatment of mental illnesses. Subsequent chapters focus on the major categories of disorders commonly identified in abnormal psychology. Closing the outline is a chapter on legal and social issues pertaining to abnormal psychology.

The current edition of this outline began with the work of Timothy W. Costello and Joseph Costello. Revisions to the text sought to maintain the quality of work and be consistent with the original authors' vision, with updates for changes in the field from revisions to the *Diagnostic and Statistical Manual* to the quickly expanding literature on abnormal biopsychology. I am largely indebted to the foundation that Timothy W. and Joseph Costello began in this outline.

Sarah K. Sife

CHAPTER I

The Field of Abnormal Psychology

Considering that approximately 44.3 million people living in the United States report meeting the diagnostic criteria for at least one psychological disorder in the past year, the issue is of top concern. Psychological disorders take many forms. They range from relatively unnoticed symptoms that largely affect only the individual with the disorder to behavior that can seriously impinge upon the rights of others. Psychological disorders also range from mild symptoms to more extreme symptoms or symptoms that seem bizarre.

In the modern world, high-tech communications reveal abnormalities around the corner as well a around the globe. Celebrities gain infamy for abuse of all kinds of substances and situations, while others are spotlighted for their suffering of such mental disorders as depression, eating disorders, and psychoses. On the societal level, whole groups of people marked by their cruelty, suicidal behavior, c common idiosyncratic behaviors have gained the attention of the world. The average person, howeve still remains only vaguely aware of psychological disorders around him or her. Perhaps one knows a person with a psychological condition but, for the most part, holds opinions about abnormal behavior that are based on bits of information or erroneous reports. Common misconceptions about abnormal behavior are that it is incurable or inherited; that those with psychological disorders are dangerous; that abnormal behavior is always bizarre; that psychological disorders come from weakness of will o immoral behavior. These statements are either totally false or apply in only limited ways. Apart from misconceptions, even the question, “How does one distinguish between normal and abnormal behavior?” is a perplexing one.

Abnormal psychology is the branch of psychology that concerns itself with establishing criteria t distinguish abnormal from normal behavior, describing the various types of abnormal behavior, searching out the causes of that abnormal behavior, seeking appropriate means of treating it, and ultimately finding ways to prevent it. More formally, we can define abnormal psychology as the scientific study of behavior that is not considered normal.

The field of abnormal psychology is such a developing one that professionals have created and repeatedly modified the most frequently used classification system of psychological disorders. Originally issued in 1952 by the American Psychiatric Association, the *Diagnostic and Statistical Manual* (DSM) lists the symptoms and other related information about widely accepted psychologica disorders. The most recently published manual, the *Diagnostic and Statistical Manual*, 4th Edition, Text Revision (DSM-IV-TR), was published in 2000. It provides a means of classifying all recognize psychological disorders and evaluating their severity. The manual uses five axes to enable clinicians to be precise about diagnosis and evaluation. The axes are:

Axis I: The clinician reports any recognized clinical syndromes except personality disorders and mental retardation.

Axis II: The clinician indicates any personality disorders or mental retardation.

Axis III: The clinician identifies any physical conditions that might affect psychological functioning.

Axis IV: The clinician specifies any psychosocial or environmental stressors that might influence the individual’s functioning, diagnosis, treatment, or prognosis.

Axis V: The clinician rates the highest level of the individual’s overall functioning.

Controversy over inclusion of such novel manifestations as “road rage” continue to divide those involved in the revisions of the DSM. So far, such additions have been thwarted by those who do not want this system to provide the criteria for every behavior that is not totally conformist or conventional. For now, however, the following definition of mental disorders is purported by the DSM.

> [A mental disorder] is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (American Psychiatric Association 2000, pp. xxi).

The DSM does not refer to the causes of mental disorders in order to avoid implying adherence to any specific theoretical orientation. It also refers to mental disorders as the product of dysfunctions that reside in individuals, not groups. Hence, according to this definition, there are no disordered groups. Although the DSM’s definition of mental disorders is generally accepted, it has been challenged for its redundancy. Using this definition requires that problematic behavior be a symptom of dysfunction in the individual if it is to qualify as an instance of mental disorder. So, the problem behavior could not itself be the dysfunction.

In the 1990s, Jerome Wakefield offered the idea of mental disorder as “harmful dysfunction.” Harm, in this definition, is explained in terms of social values (for example, suffering, the inability to work, and so on), with dysfunction referring to an underlying mechanism that does not perform according to its evolutionary design. Wakefield’s definition follows:

> A mental disorder is a mental condition that (a) causes significant distress or disability, (b) is not merely an expectable response to a particular event, and (c) is a manifestation of a mental dysfunction. (1992a, p. 235).

Although this definition is viewed as an improvement by some, there are still problems with it. Specifically, no defective operating mechanisms have been identified for most disorders. It would be quite an incredible undertaking to be able to identify a distinct underlying dysfunction that is biological in nature for the many DSM diagnoses currently in existence.

Thus, this chapter further examines the basic aspects of abnormal psychology—answering, in a basic way, questions that novices to its study often have in mind. How does one distinguish between normal and abnormal behavior? How prevalent is mental illness? What causes mental illness? Why does professional help become necessary? Where can such help be found? Who is professionally qualified to offer help?

■ WHAT IS NORMAL? WHAT IS ABNORMAL?

"Normal" and "abnormal," as applied to human behavior, are relative terms. Many people use these classifications subjectively and carelessly, often in a judgmental manner, to suggest good or ba behavior. As defined in the dictionary, their accurate use would seem easy enough: normal means conforming to a typical pattern; abnormal means deviating from a norm. The trouble lies in the word norm. Whose norm? For what age person? At what period of history? In which of the world's many cultures?

Goodness As a Criterion of Normal

Equating normal with good behavior and abnormal with bad behavior has its problems. Some questions that must be asked are these: Good or bad by whose values or standards? Under what circumstances? Is assertive behavior bad because it is disconcerting, and compliant behavior good because it is easy to accept? Is aggressive behavior always bad? Is behavior that violates parental rul bad, and behavior that conforms to parental expectations good? Is behavior that conforms to minority cultural standards but not to mainstream cultural standards bad? Psychologists who work in the field of abnormal behavior (usually referred to as clinical psychologists) have come to grips with those problems and offer more objective criteria.

Two Basic but Different Concepts of Normal and Abnormal

Social science offers two ways of distinguishing between the normal and abnormal. One way, emphasized by sociologists and anthropologists, considers the question meaningful only as it applies to a particular culture at a particular time: Abnormal is that which deviates from society's norms. Th other, stressed more by psychologists, sets as the basic criterion the individual's well-being and the maladap-tiveness of his or her behavior. The first we will call the criterion of deviance; the second, the criterion of maladaptive behavior.

Abnormal Defined As Deviation from Social Norms

The criterion of deviation from society's norms—that is, cultural relativism—provides an easy way of identifying abnormal behavior. According to this definition, if behavior differs significantly from the way in which others in the same society typically behave, it is abnormal. Cultural relativism bypasses the question of whether there are sick societies whose values are pathological, such as disregarding basic human rights. When such a sick society changes radically, for example as German did after World War II, does that make all the previously conforming individuals abnormal and all th resistive, nonconforming individuals now normal?

Another problem faced by the cultural relativists is the question of whether there are any types of abnormal behavior whose observable symptoms cut across all cultures. Emil Kraeplin's *Textbook of Psychiatry*, published in 1923, provided a basis for classifying mental illness that is still used today. Through his case studies, he felt that depression, sociopathy (fixed patterns of antisocial behavior), and schizophrenia were universal disorders, appearing in all cultures and societies. Kraeplin's astute observations were reinforced by a Swiss psychiatrist named Eugen Blueler (1857-1939), whose detailed descriptions of patients were clearly indicative of those suffering from the symptoms or clusters of symptoms (syndromes) of what we today call schizophrenia and bipolar disorder. Alois Alzheimer (1864-1915) presented an unusual clinical picture of his patients that came to be known as Alzheimer's disease. The founder of psychoanalysis, Sigmund Freud (1856-1939), described many interesting cases of what we would now recognize as specific phobia and obsessive-compulsive disorder.

There is no question that cultural factors color the symptoms of any mental illness, nor is there question that some mental illnesses appear more frequently in some cultures than in others. However most psychologists question the usefulness of social acceptability as a meaningful criterion for sortin out abnormal behavior from normal behavior.

Maladaptiveness As a Criterion of Abnormal Behavior

To reject cultural relativism requires that the individual or the society make a value judgment—one not necessarily scientifically justifiable—that some values are intrinsically good in themselves. I the United States, society has made such an initial judgment, that the well-being of the individual is important and that assuring the well-being of the individual assures the well-being of society. The Western world has followed suit, although such an individualistic orientation is not consistent across all cultures. With that value in place, instead of acceptability by the society, behavior that promotes a individual's growth and well-being is considered normal behavior, while behavior that maladaptively prevents that growth or significantly limits it is considered abnormal.

Such a criterion does not do away with all subjectivity in evaluating the normality of anyone's behavior, but it does put that decision in the hands of those who will use science to evaluate whether any given behavior is adaptive and normal or maladaptive and abnormal. "Well-being" here is given broad definition: not merely survival, but growth and fulfillment, which are paths to self-actualization. The well-being perspective allows room for the conforming behavior necessary for group cohesiveness and for deviant behavior, which may stimulate the society to re-examine itself ar its goals, so long as it is not irreparably self-damaging. It includes a concern for the well-being of families and a mission to work to eliminate those social problems that can erode a society's well-being, such as racism, discrimination, and poverty.

■ SPECIFIC CRITERIA FOR JUDGING MALADAPTIVENESS

Using maladaptive behavior as a criterion of abnormality has its own problems. It is the rare person whose behavior is never maladaptive—who never becomes angry in a self-damaging way, wh never takes one alcoholic drink more than is sensible, never feels depressed or anxious. In evaluating the maladaptiveness of behavior, psychologists consider the frequency of the behavior and the extent to which it impairs necessary functioning, especially in interpersonal relations and in occupational pursuits. They also take account of severely stressful life situations that the individual may face or catastrophic events through which he or she may have lived. Those factors may cause a transitory spell of maladaptive behavior.

There are certain kinds of conditions or behaviors that suggest the presence of psychological disorders that may benefit from psychological treatment. All those disorders, in one way or another, are maladaptive in that they threaten the well-being of the individual. A description of them follows.

Long Periods of Subjective Discomfort

Everyone goes through periods of psychological discomfort such as worry about the severity of a loved one's illness, fearful anticipation of a challenging assignment, or aggrieved feelings after an unfair criticism. But those feelings are transitory, and they are related to real or threatened events. When such feelings as anxiety and depression or frenetic behavior persist and appear to be unrelated to events sur rounding the person, they would be considered abnormal. Thoughts, feelings, or behaviors that are distressing to an individual and do not pass in a reasonable period of time suggest the possible presence of a psychological disorder.

Impaired Functioning

A distinction must be drawn between periods of transitory inefficiency and prolonged inefficienc between inefficiency whose cause can be identified and lasting inefficiency which seems to be inexplicable. Important examples that would be considered signs of an abnormal psychological condition are as follows: frequent loss of jobs or frequent job changes without apparent justification; prolonged performance notably below the individual's potential, the most common examples of whic are the very bright student who gets only low or failing grades, or the brilliantly talented person who fails in one effort after another.

Bizarre Behavior

The term "bizarre" does not refer to unconventional behavior that is carried out for some specific reason that can be understood by others—for example, behavior carried out to gain attention or to achieve notoriety. Just a mere decade and a half ago, body piercings were considered highly deviant. Today, such embellishments are considered a fashion statement and are more typically known as bod art. Rather, bizarre behavior indicative of abnormality has no rational basis, is unconnected to reality and seems to suggest that the individual is disoriented. Such behavior indicates a serious psychological disorder. These psychoses (to be described in Schizophrenia and Other Psychotic Disorders) frequently bring on hallucinations (baseless sensations), such as hearing voices when no one is present, or delusions (beliefs that are patently false, yet steadfastly held). An example is delusions of grandeur, in which an individual believes he or she is a great historical character who is long dead.

Disruptive Behavior

The implication here is impulsive, seemingly uncontrollable behavior that regularly disrupts the lives of others or deprives them of their rights. Such behavior is characteristic of several psychological disorders. The antisocial personality disorder (to be described in Personality Disorders for example, has as one of its principal characteristics conscienceless and apparently purposeless aggressive or exploitative behavior.

All of the described abnormal behaviors are maladaptive because they directly affect well-being by blocking growth and fulfillment of the individual's potential or do so indirectly and, in the long run, by seriously interfering with the well-being of others.

■ HOW COMMON ARE PSYCHOLOGICAL DISORDERS?

The study of the distribution of mental disorders is called mental health epidemiology. In considering the extent of psychological disorders, a distinction is drawn between prevalence, which i the number of individuals suffering a mental disease at a given time in a given population, and incidence, which is the number of new cases of a condition in a given period of time and population. Associated risk factors is another term used in reporting incidence, an example of which would be th lifetime expected occurrence of disorders for individuals with relatives having a mental illness.

The prevalence of abnormal behavior (mental illness or psychological disorder, as we will call it in this book) in the United States is 20.9 percent for children ages 9 to 17, 28 percent to 30 percent fo adults ages 18 to 55, and 19.8 percent (exclusive of Alzheimer's and substance abuse) for adults 55 and older. The direct costs of health services for mental disorders (including Alzheimer's disease and substance abuse) was $92 billion in 1998, and the indirect cost includes $105 billion a year in lost productivity and $8 billion a year in welfare and crime.

Prevalence of Specific Disorders

Later chapters in this outline describe in detail the variety of psychological disorders. Some classes of disorders, such as substance abuse and anxiety, are quite common, while others, such as psychoses, are less common.

Age and Gender Differences

There are both gender differences and age differences in the types of mental disorders suffered. Although men and women experience mental disorders in equal numbers, they differ in the kinds of mental illnesses affecting them. Alcoholism, for example, affects 24 percent of the male population, but only 4 percent of females. Women are more prone than men to suffer depression and anxiety, except in the Jewish culture. Drug dependence occurs most frequently in the age group of those eighteen to twentyfour; depression and alcoholism most frequently develop during the age span of twenty-five to forty-four years of age. Disorders of thinking such as dementia are most prevalent among older adults.

■ WHAT ARE THE PRINCIPAL FACTORS THAT CAUSE ABNORMAL BEHAVIOR?

In this introductory chapter, we can take only a broad-brush approach to describing causative factors in mental illness. There are three concepts that are important for you to grasp in considering the development of psychological disorders: stress, coping mechanisms, and vulnerability. It is the interaction among those elements that determines the development of mental illness. Detailed descriptions of causative elements can be found in chapters describing specific disorders.

Stress

Stress is a set of emotional tensions accompanied by biological changes (principally of the autonomic system; that is, sweating, heart pounding, blood pressure changes) caused by a threatened external event. In milder forms, it causes worry and fretfulness. The experience of some level of stre is a frequent event in everyone’s life. When the stressing external event is extreme, such as a serious automobile accident or an earthquake, or when it imposes prolonged frustration of an important human need or a bewildering conflict in which a decision is required, such as divorce, a major adjustive effort is required of the individual. That demand may push the individual into a breakdown of adaptive responses and cause the appearance of abnormal behavior. Whether that breakdown occu at all and whether it is mild or extreme depends on the existence of previously learned adaptive behavior or, in its absence, on the presence of a tendency to depend upon specific coping mechanism Existing vulnerabilities predispose the individual to the possibility of mental disorder in extremely stressful situations.

Coping Mechanisms

When faced with a stressful event or set of circumstances, a person may rise to the challenge by directing behavior primarily at dealing with the stressful event; that is, by problem-focused coping. Alternatively, the person may focus on managing his or her emotional reaction to the stressor by avoiding, distancing, or reinterpreting the stressor, which is called emotion-focused coping. Sometimes, coping behaviors are effective in managing stress, but other times, they do not successfully counter the effects of stress or else can result in additional negative consequences. Mucl

maladaptive or abnormal behavior is the result of ineffective coping behaviors.

Vulnerability

Whether individuals respond adequately to stress depends upon their vulnerability, or susceptibility, to the development of psychological disorders. There are, of course, “soft spots” or vulnerabilities in the personalities of all people, but when they are significant or multiple they can predispose the individual to break down and exhibit maladaptive behavior. Vulnerability can be due t biological (for example, genes), psychological (for example, inappropriate belief that situations are out of one’s control), social (for example, inadequate parenting), or environmental factors (for example, living in a dangerous area).

■ WHY PROFESSIONAL HELP BECOMES NECESSARY

Despite expert opinion that psychological disorders (along with physical disorders) are most effectively treated at the earliest sign of significant disturbance, many people, for one reason or another, delay treatment, deluding themselves that palliatives or self-help approaches will cure the illness. In most cases, it requires some relatively powerful influence to bring an individual to the therapist’s office. Troubled individuals finally enter therapy as a result of one of three kinds of influence: personal discomfort, the pressure of relatives and friends, and/or the demands of community or legal authorities.

Personal Discomfort

Most people who seek professional psychological help are suffering from physical or emotional discomfort. Many discomforting, even frightening, physical symptoms stem from or are made worse by emotional disorders. Among them are cancer and hypertension. Among the physical symptoms ar chronic fatigue, heart palpitations, stomach complaints, and pain. Often, the effective stimulus motivating the individual is the family physician, who has ruled out physical causes for a disorder an suggests that the person seek psychological or psychiatric assistance.

Emotional symptoms, particularly intense anxiety or spells of depression, may become so painful or alarming that they overcome whatever reasons the person may have had for delaying treatment. Many clinicians feel that a client must be experiencing notable psychological pain to persist with therapy and to respond to it.

The Influence of Family and Friends

The behavior associated with abnormal behavior may be more painful to family members or friends than to the disordered individual. Examples are abuse of alcohol, assaultive behavior, emotionally draining dependence, or exploitative behavior. Sometimes, desperate to change things, family or close friends will bring pressure on the individual to seek help. That pressure may benignly be brought to bear in a heart-to-heart talk, but strong methods are also used. Common examples include a spouse who threatens to leave; a parent who states that the house will be locked against the individual unless treatment is sought; or previously supportive friends who simply desert the individual. The kind of pressure used to induce the individual to enter therapy will, of course, have an effect on the individual’s responsiveness to treatment, sometimes causing an indifferent attendance a therapy sessions with little emotional involvement or, in other situations, causing a panic-stricken demand that the therapist do something to help.

The Influence of Legal or Community Authorities

Psychological disorders can produce behavior that is so antisocial or disruptive as to call the individual to the attention of community authorities such as a social worker to whom the family has become known, a clergy person who has tried to help, or, in extreme cases, the police or other legal authorities. With that kind of intercession, the pressure to seek therapy is made more powerful. How that power is brought to bear will also have an effect on the individual's attitude toward therapy. Individuals who have been court-ordered to receive mental health services often do so grudgingly and with little internal motivation to change.

■ WHY IS PROFESSIONAL HELP NEEDED AND WHO PROVIDES IT?

Throughout later chapters, we consider the variety of help, called therapies, available to those with psychological disorders. The first step in that process is an assessment of the individual's condition. That process leads to a diagnosis, which enables the clinician to fit the psychological troubles of the individual into a specific category of mental illness. That diagnosis gives the clinician an initial understanding of some of the elements in the individual's illness and enables the clinician to plan a course of treatment.

There are three professions that provide those helping services, either as a team or individually. They are psychologists, psychiatrists, and social workers. The academic and experiential training they receive, although different for each of the professions, prepares them in ways relevant to their discipline to offer psychological help in a skilled and responsible fashion. Beyond that primary group of mental health professionals, there are other professionals and paraprofessionals who offer specialized ancillary services, but not psychotherapy. They ordinarily work in association with psychiatrists, psychologists, or social workers.

Psychologists

These professionals, who are trained to make psychological assessments and to provide psychotherapy, will carry one of three titles: clinical psychologists, counseling psychologists, or school psychologists. Only these three categories of psychologist are trained to offer professional help for psychological disorders. Ordinarily, in five or six years of post-baccalaureate schooling, they acquire a Ph.D. (doctor of philosophy), which is a scientific degree preparing the individual for research as well as for clinical practice, or a Psy.D., (doctor of psychology), which is an applied degree providing training principally for psychological practice. During the last year of their degrees both groups complete a supervised one-year applied internship.

Clinical psychologists specialize in working with those who suffer psychological disorders. Counseling psychologists, in addition to assessment and therapy, typically offer consultation on vocational and career problems. School psychologists work mostly with children who are having school problems, the source of which may be emotional problems. All states require those three types of psychologists to pass a licensing or certification test.

Psychiatrists

These professionals are medical doctors who, after completing their medical education, spend three or four years in residence, under supervision, in a mental health facility. After that training, they may choose to become board certified by passing an examination. In most states, only physicians can write prescriptions for drugs, admit an individual to a hospital, or undertake biological forms of therapy.

Clinical Social Workers

These are professionals who have completed a two-year master's program in a school of social work, including applied internships. Some may continue on for a doctoral degree. Their training emphasizes skilled assessment, interviewing, and treatment of individuals and groups in the mental health setting. Many social workers consider individual strengths and social influences in their psychothera-peutic work.

Psychiatric Nurses

Psychiatric nurses, beyond their R.N. (registered nurse) degree, have had special training to work with individuals with psychological disorders in psychiatric hospitals. Psychiatric nurses work with individuals to develop and implement plans of care including medication, education, and other interventions. Advance practice registered nurses (APRNs) with psychiatric training also are able to conduct psychotherapy and, in some states, prescribe medication.

Occupational Therapists

Occupational therapists typically complete a master's degree in occupational therapy, plus an internship with the physically and psychiatrically challenged, focusing on helping these individuals t make the most of their resources. Occupational therapy utilizes a holistic approach to individualized interventions to develop daily living skills.

Pastoral Counselor

These professionals are usually a member of the clergy but could be lay people trained in psychology with an internship in a mental facility. This individual typically has a ministerial background and may serve as a chaplain.

Other Professionals

Psychiatric attendants or mental health technicians are a paraprofessional group who work in the psychiatric wards of hospitals. Skill therapists put into effect the suggestions of the principal therapists to provide recreational, artistic, dance, music, or occupational activities (largely crafts). They hold such titles as dance or music therapists. Case managers often have bachelor's degrees in social work or psychology and help to seek out and coordinate services for their clients.

Settings in Which Mental Health Therapists Work

A large number of mental health clinicians—that is, psychologists, psychiatrists, and social workers, work in private practice, either singly or in groups. Clients or patients are referred to them b family doctors, clergy, social agencies, insurance companies, or by former clients. Additionally, mar individuals use the phone book or Internet to locate service providers, but doing so has its risks, because there are no guarantees regarding the clinician's competence.

Other mental health professionals practice in outpatient settings, which usually are sponsored by community mental health centers or other social agencies, or are affiliated with a hospital. General hospitals and psychiatric hospitals may sponsor outpatient psychological service, but most frequently they provide service only for hospitalized patients. Some clinicians work for schools or social servic agencies.

■ SUMMARY

Abnormal psychology is the branch of psychology that establishes criteria distinguishing normal from abnormal behavior, describes the various types of abnormal behavior, searches out its causes, and seeks to find means of treating or preventing it.

The *Diagnostic and Statistical Manual* is a list of commonly accepted psychological disorders an related information. It has been revised several times and is used in classifying abnormal behavior.

Psychologists consider maladaptive behavior—that is, behavior that interferes with the individual's well-being and psychological growth—to be the overriding criterion for diagnosing abnormality. They do not consider behavior that deviates from society's norms as necessarily a sign abnormality.

There are four principal criteria for considering behavior maladaptive: long periods of personal discomfort; impaired social, educational or occupational functioning; bizarre behavior; or disruptive behavior.

In assessing the problem of mental disorders, social scientists speak of prevalence (the total number of individuals in a specific category suffering a mental disorder) and incidence (the rate at which new cases of mental disorders, usually of a particular type, will occur in a specified populatio during a stated period of time).

The principal factors causing mental disorders are stress, failure to learn adequate coping mechanisms, and vulnerability (such as genes or social risk factors).

People seek professional help because of personal discomfort, the urging of family or friends, an the influence of legal or community authorities.

There are three professional groups that offer help to victims of mental disorders. They are psychologists, psychiatrists, and clinical social workers. They are assisted by other professional groups such as psychiatric nurses, occupational therapists, and pastoral counselors, as well as such paraprofessional groups as mental health technicians, skills therapists, and case workers. These professionals tend to work in private practice, outpatient clinics, or hospitals.

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Test Yourself

1) Abnormal behavior is always incurable. True or false?

2) Abnormal psychology is defined as that branch of psychology that concerns itself with those who are gifted (those with cognitive abilities above a measured IQ of 130) and with those with mental retardation (those with a measured IQ below 69). True or false?

3) The *Diagnostic and Statistical Manual* (DSM) is a list of
   a) all possible abnormal behavior
   b) psychological disorders and related information
   c) treatments for all existing psychological disorders
   d) the prevalence of odd behaviors

4) Distinguishing normal from abnormal human behavior is difficult because it is a relative term based on a norm. The meaning of "relative" in this definition means that behavior is considered abnormal depending upon
   a) who establishes the norm
   b) the age of the person concerned
   c) the culture and time period of the person concerned
   d) all of the above

5) Goodness is an appropriate criterion to be used when comparing normal to abnormal behavior. Tru or false?

6) In his *Textbook of Psychiatry* (1923), Kraeplin found certain abnormal behaviors as universal; that is, cutting across cultures. True or false?

7) Jerome Wakefield's idea of "harmful dysfunction" is the panacea to the definition of mental disorder. True or false?

8) Which of the following is an appropriate criterion for maladjustment?
   a) significant personal discomfort
   b) immorality
   c) violation of social norms

9) Prevalence, incidence, and associated risk factors are statistics used in reporting mental illness. True or false?

10) Which of the following professionals provide psychotherapy?
   a) psychologists
   b) mental health technicians
   c) clinical social workers
   d) all of the above
   e) both a and c

Test Yourself Answers

1) The answer is **false.** Many common misconceptions exist regarding abnormal behavior including i inability to be cured. Other misconceptions are that the mentally ill are dangerous and bizarre and that mental illness derives from weakness of will or immoral behavior, or is always inherited. Mos of the preceding apply only in limited situations, if at all.

2) The answer is **false.** Abnormal psychology is that branch of psychology that concerns itself with establishing criteria to distinguish abnormal from normal behavior and providing necessary diagnostic criteria in an effort to seek the means to appropriately treat and, if possible, prevent it.

3) The answer is **b,** a list of psychological disorders and related information. The DSM does not include all possible abnormal behavior (that book would be infinitely large) or treatments for psychological disorders. Although it does include the prevalence of psychological disorders, it doe not include all odd behaviors. It does include a list of commonly recognized psychological disorders and information related to those disorders.

4) The correct answer is **d,** all of the above. The perspective of the person establishing norms, the age of the person concerned, and the culture and time in history in which the person lives are all significant factors when distinguishing normal behavior from abnormal behavior.

5) The answer is **false.** *Goodness* is subjective, depending upon personal and societal values and perspectives. A much more appropriate criterion would be the degree of deviation from societal norms or, perhaps even better, maladjustment.

6) The answer is **true.** Providing a basis for the method of classification of mental illness still in use today, Emil Kraeplin reported symptoms that seemed to cut across all cultures in the manifestation of depression, sociopathy (antisocial behavior), and schizophrenia.

7) The answer is **false.** Although Wakefield's proposal has offered a helpful step forward, it still does not provide a totally adequate definition of mental disorders. Nevertheless, his conceptualization provides the basis for a good working definition.

8) The answer is **a,** significant personal discomfort. In lieu of another cause, significant personal discomfort clearly suggests maladjustment associated with abnormal behavior. Violation of moral standards and social norms may occur in the case of a psychological disorder, but such violations d not automatically indicate a psychological disorder. For example, having an extramarital affair ma violate certain moral and societal standards, but is not a necessarily a symptom of a psychological disorder. However, an extramarital affair that occurs along with other extreme pursuits of pleasurable activities despite serious risk of personally painful consequences may be a symptom o a manic episode (discussed in Mood Disorders).

9) The answer is **true.** *Prevalence* is the number of individuals suffering a mental disease at any give time. *Incidence* reports the rate at which new cases of a specified disorder appear in the population during a stated period of time. *Associated risk factors* is an additional term used in reporting incidence that indicates the rate of a disorder in a specific population thought to be at higher risk f that disorder.

10) The answer is **e,** both a and c. Psychologists and clinical social workers both provide psychotherapy; that is, talk therapy geared toward treating psychological disorders. Mental health technicians may help implement therapeutic plans such as use of behavior modification or skills building, but do not conduct psychotherapy.

CHAPTER 2

The History of the Problem of Abnormal Behavior

The problem of mental disorders is as old as humankind. Recorded history reports a broad range of interpretations of abnormal behavior and methods for correcting it, which have generally reflected th degree of enlightenment and the trends of religious, philosophical, and social beliefs and practices of the times. It is not surprising that earlier efforts to deal with the problem were fraught with difficulti and that the evolution of the science of abnormal psychology has been painfully slow. This has been the case for two reasons.

First, the very nature of the problems caused by abnormal behavior has made it a "thing apart," arousing fear, shame, and guilt in the families and communities of those afflicted in many cultures. Hence, the management of the mentally disordered has been turned over to the state and the church, which have been the traditional guardians of both group and individual behavior. Second, the evolution of all the sciences has been slow and sporadic. Many of the most important advances have been achieved only against great resistance. Although this has been more typical of abnormal psychology than of other disciplines, the difference is only relative. In reviewing the historical account that follows, one should not be too critical. Although it is true that in earlier times the abnormal person was misunderstood and often mistreated, the lot of the "normal" individual was not much happier one.

■ PRIMITIVE PERIOD

Archaeological findings suggest that some types of mental illness must have been recognized as far back as the Stone Age. Skeletal remains from that period reveal that attempts were made to reliev brain pressure by chipping away an area of the skull. Although the procedure was similar to the operative technique now known as trephining, there is serious question as to whether it was based on any knowledge of brain pathology. It seems more likely that the operation was performed in the belie that, in this way, an avenue of escape was provided for "evil spirits." Our knowledge of primitive psychiatry does not go beyond speculations suggested by such skeletal remains.

■ PRECLASSICAL PERIOD

Although primitive superstitions persisted into and beyond the Classical period, history shows th attempts were being made before the classical ages of Greece and Rome to find a more rational approach to the understanding and treatment of the mentally disordered.

In Asia

About 2600 B.C.E., in China, forms of faith healing, diversion of interest, and change of environment emerged as the chief methods for treating mental disorders. By 1140 B.C.E., institutions for the "insane" had been established there, and patients were being cared for until "recovery." In the writings of physicians in India around 600 B.C.E. are found detailed descriptions of some forms of mental disease and epilepsy, with recommendations for kindness in treatment.

In the Middle East

Egyptian and Babylonian manuscripts dating back to 5000 B.C.E. describe the behavior of the mentally disordered as being due to the influence of evil spirits. Aside from the practice of trephining (opening the skull), treatment was restricted almost exclusively to the work of priests and magicians. Biblical sources indicate that the Hebrews looked upon mental illness as a punishment from God and that treatment was principally along lines of atonement to him.

■ CLASSICAL PERIOD

As in all areas of scientific and social thought, important strides were made toward a more reasonable and humane treatment of the mentally ill in the era of classical Greece and Rome. It was a this time that the first glimmer appeared of a medical approach to the problem.

In Greece

Some of the more significant assumptions of Greek thought have been confirmed by modern research, and much of the terminology of modern psychiatry (as of medicine and science in general) a legacy from this period. The humane, rational approach to mental illness that emerged during this era was due largely to the findings of the following people.

Pythagoras (circa 500 B.C.E.)

Before 500 B.C.E., priest-physicians combined the use of suggestion, diet, massage, and recreatic with their more regular prescriptions of incantations and sacrifices; however, in all treatment, the guiding motive was appeasement of good or evil spirits. Pythagoras was the first to teach a natural explanation for mental illness. He identified the brain as the center of intelligence and attributed mental disease to a disorder of the brain.

Hippocrates (460-377 B.C.E.)

Hippocrates, the father of medicine, held that brain disturbance is the cause of mental disorder. H emphasized that treatment should be physical in nature, urging the use of baths, special diets, bleeding, and drugs. Hippocrates taught the importance of heredity and of predisposition to mental illness. He related sensory and motor disturbances to head injuries. Anticipating modern psychiatry, he also believed that the analysis of dreams can be useful in understanding the patient's personality.

Plato (428-347 B.C.E.)

The Greek philosopher Plato displayed keen insight into the human personality. He recognized th existence of individual differences in intelligence and in other psychological characteristics, and he asserted that man is motivated by "natural appetites." To Plato, mental disorders were partly moral, partly physical, and partly divine in origin. He described the patient-doctor relationship in the treatment pattern, believed that fantasy and dreams are substitute satisfactions for inhibited "passions," and introduced the concept of the criminal as a mentally disturbed person.

Aristotle (384-322 B.C.E.)

Aristotle accepted a physiological basis for mental illness, as taught by Hippocrates. Although he did consider the possibility of a psychological cause, he rejected it, and so strong was his influence o

philosophical thought that for nearly 2,000 years, his point of view discouraged further exploration along these lines.

***Alexander the Great (356-323* B.C.E.)**

Alexander established sanatoriums for the mentally ill where occupation, entertainment, and exercise were provided. These practices were continued during the later Greek and Roman periods.

In Rome

The Romans, for the most part, continued to follow the teachings of the Greek physicians and philosophers in their treatment of mental illness. Greek physicians settled in Rome, where they continued their studies and teaching.

Aesclepiades (124-40 B.C.E.)

This Greek-born physician and philosopher was the first to differentiate between acute and chron mental illness. He developed mechanical devices for the comfort and relaxation of mental patients. Additionally, he opposed bleeding, restraints, and isolation in dungeons. Whereas his predecessors ha considered both delusions and hallucinations under one heading (phantasia), Aesclepiades differentiated between the two.

Aretaeus (C.E. First-Second Centuries)

Aretaeus was the first to suggest that mental illness is an extension of normal personality traits. H believed that there existed a predisposition to certain forms of mental disorders. One of his original thoughts was placing the location of mental disease in the brain and the abdomen, which foreshadowed the psychosomatic approach to medicine.

Galen (C.E. 129-199)

Galen's contribution to medical science, although of great value in one respect, served to impede development in another. Like Hippocrates, who lived seven centuries earlier, he gathered and organized an enormous amount of data concerning mental and physical illness and conducted studies in the anatomy of the nervous system and its relation to human behavior. He recognized the duality o physical and psychic causation in mental illness, identifying such varied factors as head injuries, alcoholism, fear, adolescence, menopausal changes, economic difficulties, and love affairs. Because his prestige was great, progress was encumbered by controversies over the metaphysical aspects of h contributions and, thus, independent thinking in the medical sciences was delayed until well into the eighteenth century.

In Arabia

The last faint echo of the efforts of the classicists to conquer the problem of mental disorder was heard not in the West, but in Arabia, where Avicenna (C.E. 980-1037) and later, his follower, Averrhoes (C.E. 1126-1198), maintained a scientific approach to the mentally ill and urged humane treatment. Elsewhere, as we shall see, a return to primitive notions prevailed.

■ MEDIEVAL PERIOD

With the dissolution of the Greco-Roman civilization, learning and scientific progress in Europe experienced a grave setback. Ancient superstitions and demonology were revived and contemporary the ological thinking did little to discourage the "spiritistic" approach to the problem of mental illness. Exorcism (expelling an evil spirit) was considered imperative, and incantations were regarde as a legitimate adjunct of medicine. Even the application of rationally based techniques had to be accompanied by the pronouncement of mystical phrases. The physicians of the time tended to use amulets. For example, Alexander of Tralles (C.E. 525-605), who stressed the importance of physical factors and related them to specific types of mental disorders, treated colic by the application of a stone on which an image of Hercules overcoming the lion was carved.

The Dancing Mania

At intervals from the tenth to the fifteenth centuries, the dancing mania, also referred to as "mass madness," in which large groups of people danced wildly until they dropped from exhaustion, was seen in Europe. In Italy, the condition was called tarantism, because the mania was thought to be due to the bite of the tarantula. Elsewhere in Western Europe, the mania was called Saint Vitus's dance. I is difficult to say whether these seemingly epidemic manifestations have been greatly exaggerated in the telling. It has been suggested that a large number of people were suffering from various forms of chorea (a disease associated with involuntary jerky movements). Fear of this unexplained disorder may have resulted in mass suggestibility and hysteria, which mounted unchecked and subsequently was recorded as a single clinical entity.

Witchcraft: Belief in Demonology

The period from the fifteenth to the eighteenth centuries comprises a sorry chapter of history with respect to the fate of the mentally ill. Their afflictions were generally ascribed to possession by the devil. Treatment, consisting chiefly of attempts to "cast out the demon," was hardly distinguishable from punishment. The Black Death (bubonic plague) had ravaged Europe in the fourteenth century an the resulting depression and fear rendered people highly susceptible to accusations of witchcraft. The humane, scientific approach to the mentally ill (for that matter, to all illness) was indeed at a low ebb

Late in the fifteenth century, the plight of people with abnormal behavior was intensified by the publication of *Malleus Maleficarum (The Hammer of Witches)* by Henry Kraemer and James Sprenger. Their book, appearing in 1486, was to be the handbook of inquisitors for two hundred years Courts of the Roman Catholic Church searched out persons thought to be "possessed of the Devil," and the unfortunates were then turned over to civil authorities to be tortured or executed. Sprenger an Kraemer met some early resistance from cooler heads in the church and community but soon won support from people already full of a fear of witchcraft. Their crusade caught fire and thereafter spread throughout both Roman Catholic and Reformed centers in Europe. So widely held was the belief in witches that the persecution of witches continued off and on for the next three centuries.

Institutional Care of the Mentally III

The kind of institutional care afforded the mentally ill during the late medieval and early Renaissance periods was that seen at "Bedlam" (the name is a contraction of Bethlehem). As early as 1400, the monastery of Saint Mary of Bethlehem in London began caring for "lunatics" and in 1547, the monastery was officially converted into a mental hospital. Because of the inhumanity of the treatment there, "bedlam" has come to stand for anything that is cruel in the management of the mentally ill. But this era was not entirely without examples of tolerance and mercy. The shrine of

Saint Dymphna at Geel in Belgium (established in the fifteenth century) not only lent solace to thousands of afflicted persons who visited there but also grew gradually into a colony that was dedicated to the care of the mentally ill. Its work still goes on, and Geel is regarded as the model for similar cottage-structure psychiatric institutions and community-living organizations elsewhere.

■ RENAISSANCE PERIOD

Although those with mental disturbances became engulfed in a morass of superstition and inhumanity, voices of reason were raised in certain countries of Europe by enlightened people of religion, medicine, and philosophy. Their efforts during this period can well be described as lights in the darkness.

In Switzerland

Paracelsus (Theophrastus von Hohenheim), 1493-1541, rejected demonology, recognized psychological causes of mental illness, and proposed a theory of "bodily magnetism," a forerunner of hypnosis. Like Hippocrates, he suggested the sexual nature of hysteria. However, like so many otherwise reasonable men of his time, he laid great store on astral influences, assigning to various planets control over specific organs of the body.

In Germany

Heinrich Cornelius Agrippa (1486-1535) fought against the hypocrisy and bloodthirsty applicatio of law of the Inquisition. A scholar, Agrippa was persecuted and reviled for his views and died in poverty. Johann Weyer (1515-1588) was a physician who studied under Agrippa. In 1563, he published a scientific analysis of witchcraft, rejecting the notion of demon causation in mental illnes His clinical descriptions of mental disorders were remarkably concise and uncluttered with opinions and theological illusions. Weyer is regarded by some as the father of modern psychiatry.

In England

Reginald Scot (1538-1599) published a scholarly, painstaking study titled *The Discovery of Witchcraft: Proving That the Compacts and Contracts of Witches and Devils ... Are but Erroneous Novelties and Imaginary Conceptions.* But King James I ordered the book seized and burned, and the king published a refutation of Scot's views.

In France

Saint Vincent de Paul (1576-1660) urged a more humane approach to the mentally ill. He emphasized the fact that mental diseases differ in no way from bodily diseases. In the hospital he founded at Saint Lazare, he put into practice what he held to be a basic Christian principle; namely, that we are as much obligated to care humanely for the mentally ill as for the physically ill.

■ EIGHTEENTH TO TWENTIETH CENTURIES

The transition from the demonological to the scientific approach to mental illness was not accomplished overnight. In France, for example, capital punishment for convicted "sorcerers" was no abolished until 1862. The first general trend toward specialized treatment of the mentally ill probably came in the wake of the social, political, economic, and scientific reforms that characterized the latte

half of the eighteenth century.

In France

Soon after the Revolution, Philippe Pinel (1745-1826) removed the chains from the inmates at Bicetre and provided pleasant, sanitary housing, along with walkways and workshops. Later, at Salpetriere, he introduced the practice of training of the attendants. Jean Esquirol (1772-1840) continued Pinel's work and through his efforts, ten new mental hospitals were established in France.

In England

William Tuke (1732-1822), a layman and a Quaker, interested the Society of Friends in establishing the York Retreat in 1796. Through his urging, special training was instituted for nurses working in this field. John Conolly (1794-1866), founder of a small medical association which later became the British Medical Association, was mainly responsible for the wide acceptance of nonviolent measures in the treatment of the mentally ill.

In Germany

Anton Muller (1755-1827), working in a hospital for mental diseases, preached humane treatmen of the insane and protested against brutal restraint of patients.

In Italy

Vincenzo Chiarugi (1759-1820) published his *Hundred Observations* of those with mental illness and demanded humanization of treatment of individuals with psychological disorders.

In Latin America

The first asylum for the "insane" in the Americas was San Hopolito, organized in roughly 1570 b Bernadino Alvarez in Mexico City, but it is difficult to say whether it was really more than a place o confinement. Elsewhere in Latin America, the earliest mental hospitals began to appear in the 1820s. As late as 1847, visitors to Mexico and Peru reported that "lunatics" were displayed for the amusement of the public, who paid for the exhibition (as had been done at Bedlam three centuries earlier).

In the United States

In Philadelphia, the Blockley Insane Asylum was opened in 1752. The only other institution for t mentally disturbed in the United States before the nineteenth century was the Eastern State Lunatic Asylum in Virginia, opened in 1773.

Humanitarian treatment of the mentally ill was encouraged by Benjamin Rush (1745-1813), who generally accepted as the father of American psychiatry. Rush organized the first course in psychiatr and published the first systematic treatise on the subject in the United States. In the latter half of the nineteenth century, Dorothea Lynde Dix (1802-1887) carried on a militant campaign for reform in th care of people with psychological disorders. She was responsible for a more enlightened attitude and improved programs in twenty states. In New York, her efforts resulted in the State Care Act of 1889, which did away with confinement of individuals with mental illnesses in jails and almshouses. Her influence was felt also in Canada, Scotland, and England.

At Utica State Lunatic Asylum (now Utica State Hospital), an Association of Superintendents of

American Institutions for the Insane was formed in 1846. The name was changed to American Medico-Psychological Association in the 1880s. It finally became the American Psychiatric Association of today. Its professional scientific publication, originally called the *American Journal o Insanity* (now called the *American Journal of Psychiatry)*, has been published continuously for over 150 years.

In the early years of the twentieth century, Clifford Beers (1876-1943) described his experiences as a mental patient in the book *A Mind That Found Itself.* The wide distribution of this volume stimulated public interest in a movement to improve conditions in mental hospitals and gave rise to the formation of the National Committee for Mental Hygiene, in which Beers played an active role. That organization was later incorporated, along with other smaller groups, into the National Mental Health Association.

In the Western World: National and International Efforts

The mental hygiene movement spread throughout the Western world. During the first half of the twentieth century, a variety of national and international organizations were established to aid in the development of improved facilities for the mentally ill. In recent decades, there has been a trend toward public acceptance of both humanitarian and scientific approaches to the problem of mental abnormality. This new attitude has been reflected in the activities of world organizations such as the World Health Organization, UNESCO (United Nations Educational, Scientific, and Cultural Organization), and the World Federation of Mental Health, as well as in those of innumerable nationa and local public and private agencies. (For a discussion of modern treatment approaches, see Psychodynamic Forms of Psychotherapy and Behavioral, Cognitive, and Biogenic Therapies.)

Deinstitutionalization

In the 1970s, conditions in institutions for individuals with psychological disorders in the United States were exposed to still be inhumane and overly restrictive. This brought about pressure from consumers of psychological services, families of individuals in the institutions, and the general publi to move toward less restrictive care. The pressure resulted in a trend known as deinstitutionalization; that is, the placement of individuals with psychological disorders in the community rather than institutions and the provision of psychological services in community settings.

Legislation was passed requiring the formation of community mental health systems to serve suc individuals. The community mental health system, while often struggling to meet demand for service with limited resources, has increased the number of services available for those with mental disorder in communities. Additionally, public and private agencies have created group homes and other communityliving arrangements for individuals with severe psychological and developmental difficulties.

As individuals moved out of institutions, many state and private psychiatric institutions closed. The unfortunate difficulty in deinstitutionalization is that often there are not sufficient services to support individuals with mental illnesses in their communities. This has resulted in a large number o individuals not receiving appropriate care and sometimes ending up homeless or in jails or prisons.

■ THE MODERN ERA: DEVELOPMENTS IN PSYCHIATRIC THOUGHT

The development of psychiatric thought and the subsequent contributions to the understanding of mental abnormality during the eighteenth to twentieth centuries may be summarized under two headings: organic interpretations and psychological interpretations.

Organic Interpretations

The importance of brain pathology in the causation of mental illness was recognized by Albrecht von Haller (1708-1777), who sought corroboration of his beliefs through postmortem studies. In 184 William Griesinger (1817-1868) published his *Pathology and Therapy of Psychic Disorders*, in whic he held that all theories of mental disturbances must be based on brain pathology. The psychiatrist Henry Morel (1809-1873) attributed mental illness to hereditary neural weakness. Valentin Magnan (1835-1916) investigated mental illness occurring in relation to alcoholism, paralysis, and childbirth

Perhaps the most influential figure in psychiatry in the latter nineteenth and early twentieth centuries was Emil Kraepelin (1856-1926). In 1883, he published a textbook outlining mental illness in terms of organic pathology. He focused on the disordered functioning of the nervous system in particular, a point of view that oriented his approach to the general problem of mental disturbances. He described and classified many types of disorders and provided a basis for descriptive psychiatry b drawing attention to clusters of symptoms. Kraepelin evolved a theoretical system that divided menta illness into two large categories: those due to endogenous factors (originating within the body) and those due to exogenous factors (originating outside the body). His classification remained substantially unchanged until a few years after World War I. Kraepelin made notable contributions t psychiatry, but his approach to mental illness was that of an experimentalist and, consequently, he studied disease processes as entities in themselves rather than as the dynamic reactions of living individuals.

In 1897, Richard von Krafft-Ebing (1840-1902), a Viennese psychiatrist, disclosed experimental proof of the relationship of general paresis (a psychosis) to syphilis (see Organic Disorders). In 1907 Alois Alzheimer established the presence of brain pathology in senile psychoses (later known as Alzheimer’s disease). In 1917, Julius Wagner-Jauregg (1857-1940) inoculated nine paretic patients with malaria, with consequent alleviation of their condition. These and other discoveries during the early twentieth century lent strong support to the believers in the organic approach to mental illness.

Early biological treatments for mental illness often were discovered by accident and had significant negative effects or risks. In the 1920s, both insulin and electricity were used to induce convulsions to treat schizophrenia and depression. Although this was sometimes effective in improving symptoms, it also resulted in unintended side effects and even, in some cases, death. Electroconvulsive therapy (ECT) is still used in a greatly modified way to treat depression that does not respond to less extreme treatments.

In the 1930s, lobotomies (a form of psychosurgery where part of the brain is destroyed or removed) began to be used to treat psychoses and aggressive behavior. The lobotomy fell out of favo in the 1950s when research continued to indicate that lobotomies were no better than chance in improving the symptoms they were designed to treat and that they resulted in significant harm and, occasionally, death.

In the 1950s, neuroleptics and tranquilizers were developed and used to treat psychoses, anxiety, and other psychological concerns. Unfortunately, both classes of medications were found to be only partially effective and to carry significant side effects and risks. Since then, medications have continued to improve, showing fewer side effects and greater effectiveness as development continues

Psychological Interpretations

Despite the achievements of the organically oriented investigators in certain limited areas, very little progress was being made in treating patients with mental disorders. As early as the first decades of the eighteenth century, vague and uncertain theories (for example, mesmerism) had postulated